

**South Carolina Department of Labor, Licensing and Regulation**  
**Board of Medical Examiners**  
**P.O. Box 11289, Columbia, SC 29211**  
**Telephone number (803) 896-4500**

**2013 – 2015    Renewal Application for:** \_\_\_\_\_ **License #:** \_\_\_\_\_

**Renewal Instructions**

1. Complete all questions, blank spaces, and **sign and date application on back of form. Incomplete applications will be returned.**
2. Information in our files is pre-printed on this form. Make any necessary corrections and attach additional sheets as necessary.
3. **Mail completed application with a payment of \$160.00 made payable to LLR-Board of Medical Examiners.** Applications must be postmarked by the Post Office on or before July 1, 2013.

**Home Address**

**Primary Place of Employment**

**Mailing Address**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**County:** \_\_\_\_\_

**County:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**Fax:** (    ) \_\_\_\_\_

**Cell Phone:** (    ) \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

(Confidential Info for DHEC Emergency Contact System)

**Hrs./Wk:** \_\_\_\_\_

**Home Congressional District:** \_\_\_\_\_

**Specialty:** \_\_\_\_\_

**Contact your voter registration office to obtain congressional district information. Failure to provide this information will render your application incomplete, causing delays and possible penalties.**

**Type of Practice:**

(An asterisk (\*) following Type of Practice indicates American Board of Medical Specialties' Certification, American Osteopathic Association Certification, or other approved equivalent board certification. If the information listed above is incorrect, please furnish a copy of the appropriate certificate with this application.)

**SC Activity Status (Check one only) Currently on File:** \_\_\_\_\_

☐ 01Currently practicing Medicine    ☐ 02Temp not practicing Medicine    ☐ 08Retired

**Primary Practice Setting (Where patients are seen initially) Currently on File:**

☐ 44Admin/Regulatory Hlth Agency    ☐ 22Fed Non-Military Hlth Facility    ☐ 11Hosp, Non-Fed General    ☐ 15Private Office  
☐ 50Business Establishment    ☐ 27Free-Standing Amb Surgery Ctr    ☐ 23Hosp, Non-Fed Psy    ☐ 31Univ/College of Med  
☐ 20Comm Hlth Ctr, Rural Hlth Cln    ☐ 13Free-Standing Clinic    ☐ 24Hospital, Non-Fed Rehab    ☐ 71Other specify:  
☐ 21Fed Military Hlth Facility    ☐ 29Free-Standing Emerg/Urgent Care    ☐ 14Outpat Mental Hlth Clinic    \_\_\_\_\_

**Form of Practice (Source of Income) Currently on File:**

☐ 32County Gov    ☐ 28Non-profit Hlth Agency    ☐ 11Self, Solo    ☐ 33State Gov  
☐ 34Fed Civilian (Incl. USPHS)    ☐ 25Other Private Emp    ☐ 13Self, Group, Same Specialty    ☐ 44Volunteer  
☐ 35Fed Military    ☐ 43Resident/Intern Training    ☐ 14Self, Group, Multi-Specialty    ☐ 42Other specify: \_\_\_\_\_

**In your primary place of employment, would your position be best described as Hospitalist?"** ☐ Yes ☐ No

**Secondary Locations of Practice in S.C.**

1.	City	County	Specialty	Setting	Hrs./Wk.

  

2.	City	County	Specialty	Setting	Hrs./Wk.

**Hours Per Week Spent In:**

Total	Patient Care	Administration	Teaching	Research	Training	Other

**Hours Per Week Spent In Specialties (Should add to total hours above):**

Primary Specialty	Hrs./Wk.	Secondary Specialty	Hrs./Wk.	Tertiary Specialty	Hrs./Wk.

**Indicate all South Carolina hospital affiliations, which you presently have:**

1.
2.
3.

1. Please check this box if you are willing for your name to be added to a list of volunteer physicians who may be called upon in the event of a public health emergency. ☐

Answer "Yes" or "No" to each of the following questions. If your answer is "Yes" to questions 2-9, below, you must attach a full written explanation. \*\*Since your last renewal, if you have voluntarily enrolled in a Recovering Professional Program and have remained in full compliance; you may answer "No."

2. Since you last registered with this Board, has any Order or other disciplinary action been rendered against you by any Medical Board (other than SC Board) or have you been denied licensure by any other Medical Board? ☐ Yes ☐ No
3. Since you last registered with this Board, have any hospital privileges or other privileges of any kind been revoked, suspended, restricted, denied, voluntarily surrendered or relinquished? ☐ Yes ☐ No  
(Include the relinquish of privileges while under investigation or pending action for any reason. Do not include the relinquishment of privileges as a result of a personal decision.)
4. Since you last registered with this Board, has your ability to practice medicine been impaired by any physical, emotional or mental illness, whether temporary or permanent? \*\* ☐ Yes ☐ No
5. Since your last registration for renewal of your license, have you been treated for any physical, mental, or emotional conditions that might interfere with your ability to competently and safely perform the essential functions of practice? \*\* ☐ Yes ☐ No
6. Since your last registration for renewal of your license, have you developed any disease or conditions, physical, mental or emotional (i.e. bipolar disease, schizophrenia, paranoia or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice? \*\* ☐ Yes ☐ No
7. Since your last registration for renewal of your license, have you been arrested, indicted or convicted, pled guilty or pled nolo contendere for violation of any federal, state or local law (other than minor traffic violations)? ☐ Yes ☐ No
8. Since you last registered with this Board, have you voluntarily restricted or curtailed your practice other than retirement, family leave or vacation? \*\* ☐ Yes ☐ No
9. Do you plan to be in a residency training program from July 1, 2013 to June 30, 2015? ☐ Yes ☐ No
10. Have you changed specialty since your last renewal? ☐ Yes ☐ No
11. Do you supervise procedures involving the use of devices such as lasers, intense pulse light (IPL), microwaves, infrared, etc.? ☐ Yes ☐ No  
If so, which procedures do you delegate to others?
12. Has there been any change in the status of your lawful presence in the United States since initial licensure? ☐ Yes ☐ No

**Continuing Education**

13. Continuing Education: Have you documented evidence of continued competency during the last two consecutive calendar years prior to this renewal? (1/1/2011 - 12/31/2012) MD's and DO's who are in their first renewal cycle after receiving their initial permanent license are not required to report CME for this renewal year only. If this applies to you, please check yes. (Do not submit copies of your continued competency documentation. A random audit will be conducted at the end of the registration period.) ☐ Yes ☐ No

I have carefully read all questions on this renewal application and have answered truthfully, accurately and completely. I hereby acknowledge that failure to answer these questions truthfully, accurately and completely shall constitute cause for the initiation of disciplinary action against my South Carolina license and rejection of this application or delay in processing.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**If your name has changed, please provide the Board with a copy of the legal document.**

**Fee Schedule**

\$ 160.00 – April 1 – June 30, 2013

After June 30, 2013, your license will be reflected as lapsed on the Board's Licensee Lookup web page and you will be charged \$100 per month late fee.

S.C. Code Section 40-47-41 states in part "...A licensee shall notify the board in writing within fifteen business days of any change of residential address, office address, or office telephone number." Failure to maintain a current address could result in important correspondence not reaching you.